Office of Research & Policy Analysis

Diverting the Mentally Ill from the Justice System and Providing Involuntary Commitment Alternatives

A REPORT TO THE 61ST LEGISLATURE

From the
Law and Justice Interim Committee

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EXECUTIVE SUMMARY

Assigned studies

The Legislative Council assigned the following joint study resolutions passed by Montana's 60th Legislature to the Law and Justice Interim Committee (LJIC) for the 2007-2008 interim:

- SJR 6 - study of the juvenile justice system;
- SJR 24 - study of prison population growth and alternatives for diverting drug offenders to treatment;
- HJR 26 - study of mental health treatment and diversion alternatives for justice-involved adults and youth; and
- HJR 50 - study of involuntary precommitment process and costs.

Copies of these study resolutions are provided at Appendix A.

Four main recommendations

The Law and Justice Interim Committee (LJIC) recommends to the 61st Legislature the enactment of four bills to divert mentally ill individuals from the criminal justice system and from involuntary commitment at the Montana State Hospital (MSH) and to assist counties with costs for crisis intervention, jail suicide prevention screening, and precommitment costs:

- HB 130 (LC0307) - establishing a grant program for county crisis intervention and jail diversion programs. The preliminary cost estimate is $615,937 from the state general fund in each year of the biennium.
- HB 60 (LC0329) - establishing a pilot project for a statewide jail suicide prevention program. The preliminary cost estimate is $264,000 for FY2010 and $189,000 from the state general fund for FY2011.

- HB 131 (LC0516) - requiring that DPHHS contract for up to three secure psychiatric treatment beds in each of four mental health regions. The preliminary cost estimate is $410,625 from the state general fund in each year of the biennium.

- HB 132 (LC0517) - allowing an involuntary commitment hearing to be suspended if the respondent agrees to be diverted to a 14-day short-term inpatient treatment program and requiring that DPHHS contract for up to three short-term inpatient treatment beds in each of four mental health regions. The preliminary cost estimate is $1.7 million from the general fund in each year of the biennium.

An explanation of the issues identified in the study process and highlights of the research findings are provided in Part I of this report.

The introduced versions of each of these bills are provided at Appendix B.

Other recommendations

Other recommendations relevant to the assigned studies, but not highlighted in this report, are as follows:

- SB 35 (LC0589) - requiring that when an inmate is being transferred to prison, all mental and physical health information in the possession of a jurisdiction be forwarded to the prison at the time the prisoner is transferred.[*]

- SB 91 (LC0198) - requiring that a youth be represented by an attorney at a probable cause detention hearing unless that right is waived after consultation with an attorney.

[*] For more information, see LJIC meeting materials and minutes for June 26, 2008, and David Niss, *No. 6 - Legislation and Administrative Issues Concerning Transfer of Mental Health Information Between MSP and Counties*, legal memorandum dated June 13, 2008.

In addition to conducting its study assignments, the LJIC is responsible for on-going oversight and monitoring of matters related to the Department of Corrections, the Department of Justice, and the Judicial Branch. In the course of exercising these general duties, other issues arose. To address these, the LJIC recommends enactment of the following other bills:

- SB 50 (LC0364) - revising salaries for supreme court justices and district court judges.*
- SB 125 (LC0199) - adding Judicial District 22 to the list of judicial districts represented on the judicial nomination commission.
- SB 10 (LC0299) - striking obsolete language concerning federal funding to research the impact of drug courts.

Special notes

Reference material

The LJIC's minutes, exhibits, staff reports, and other meeting materials, including audio files for meetings held in Helena, are available online at www.leg.mt.gov by following the the links for interim committees, the Law and Justice Interim Committee, and the 2007-2008 interim.

Terminology note

Throughout this report the term "jail" is used but means any local detention center whether it is operated by a city, county, or regional cooperative.

* This issue was brought by Sentator Shockley to the LJIC at its April 10-11, 2008, meeting. A National Center for State Courts survey showing Montana's judicial salaries rank 51st among the 50 states and the District of Columbia, and other related materials are available online at the committee website, www.leg.mt.us, following the links to the LJIC 2007-2008 website and meeting materials for April 10-11, 2008.

Organization and abbreviations

Part I includes separate sections on each of the four primary bills being recommended by the LJIC. Endnotes are provided at the end of each section. Because these sections may be extracted and used separately, some of the research findings are intentionally repeated.

PART I - HJR 26 AND HJR 50
STUDIES OF MENTAL HEALTH TREATMENT IN THE JUSTICE SYSTEM AND INVOLUNTARY PRECOMMITMENT PROCESS AND COSTS

Study priorities

- The HJR 26 study tasks were to examine mental health treatment in the adult and juvenile justice systems and options for diverting people from incarceration to treatment. The youth portion of the study is summarized under Part II along with the SJR 6 study of the juvenile justice system.

- The HJR 50 study tasks were to examine the precommitment process and costs for involuntary commitment to the Montana State Hospital, to identify ways to streamline the system and allow for more timely resolution of involuntary commitment proceedings, and to improve the ability of counties to predict and budget for costs.

Key activities

- The study plan was designed using the National GAINS Center's sequential intercept model as a blueprint for study activities.[1] The Law and Justice Interim Committee (LJIC) conducted panel discussions on each intercept in the model.

- The LJIC examined constitutionally-required standards for mental health treatment of inmates.

- For the HJR 50 study of involuntary precommitment costs, the LJIC gathered research, held panel discussions, and surveyed all 56 of Montana's counties.

Recommended legislation

As noted in the Executive Summary, the following bills are the LJIC's core recommendations and each are discussed in separate sections within this part:

- HB 130 (LC0307) - establishing a grant program for local crisis intervention programs *(to be carried by Rep. Stoker);*

- HB 60 (LC0329) - establishing a pilot program for jail suicide prevention screening *(to be carried by Rep. Ebinger)*

- HB 131 (LC0516) - requiring state contracting for regional emergency detention beds *(to be carried by Rep. Stoker);* and

- HB 132 (LC0517) - providing for diversion from involuntary commitment to short-term treatment *(to be carried by Rep. Stoker)*.

Is there overlap in purpose and funding?

As illustrated in the following diagram, these bills work together to address: (1) initial contact with law enforcement, crisis intervention, jail diversion, and jail suicide prevention; (2) emergency detention and treatment beds; (3) short-term inpatient treatment beds as an alternative to involuntary commitment. Questions about seeming overlaps in purpose and funding may arise. It is not the intent that passage of all of these bills will fund the same services twice. It is the intent that the funding be used to seamlessly connect each piece to the other.

How the Four Key Bills Work Together

Initial Response

Now: No state funding for:
-crisis training for law enforcement
- mental health professional crisis response teams

Needed: Crisis centers for initial screening
- collaborations like Billings Crisis Center and Billings Clinic offer local solutions, funding needed

Now: Jail diversion required by state law, but no state funding provided
High jail suicide rates

Emergency Detention

Now: Patrol car therapy
- transport to MSH
- involuntary commitment proceeding initiated

LC0516 = LOCAL ALTERNATIVE regional beds for emergency detention and evaluation
-reduces admissions to MSH
-reduces county transportation costs

Treatment

Now: Involuntary commitment hearing, commitment determination
- court delays
- increased treatment costs for counties

Now: Commitment is to MSH for up to 90 days
- involuntary
- stigma of commitment

HB 132 (LC0517) SHORT-TERM TREATMENT:
- provided locally/regionally
- no commitment hearing
- voluntary agreement
- no stigma
- reduces MSH admissions
- reduces county precommitment costs

HB 130 (LC0307) - Grant Program
(Rep. Stoker)
- DPHHS to administer
- reimburse up to 50% of local costs for eligible expenses, such as CIT training, crisis response teams, jail diversion, if DPHHS determines these to be eligible expenses
- Includes incentive to participate in LC0329 program, and precommitment cost insurance
- Cost: $615,937 annually (preliminary est.)

HB 60 (LC0329) - Jail Suicide Prevention
(Rep. Ebinger)
- pilot project
- DPHHS to contract with mental health provider
- inmates screened via telephone or video
- jail risk management protocols triggered
- follow-up services if needed
- Cost: $264,00 in FY2010; $189,000 in FY2011

HB 131 (LC0516) - Contracting for regional beds *(Rep. Stoker)*

- DPHHS to contract for beds
- up to 3 beds in each mental health region
- for emergency detention and evaluation
- contract can allow local flexibility
- Cost: $410,625 annually (prelim. est.)
- *supports LC0307 and LC0329 jail diversion and crisis intervention programs by providing a place to go other than jail or the MSH*

HB 132 (LC0517) - Diversion to short-term treatment
(Rep. Stoker)

Process streamlined
- court hearing on involuntary commitment suspended if attorneys and respondent agree to short-term treatment
- 14 days, can be released earlier
- hearing held if treatment refused, longer treatment needed, attorney requests

Contracting for local beds
- DPHHS to contract for up to 3 bed each region
- Cost: $1.7 million annually (prelim. est.)

HB 130 (LC0307) - GRANT PROGRAM FOR LOCAL CRISIS INTERVENTION SERVICES

Problem

As national studies and Montana's own newspaper headlines attest, people with mental illness are falling through the cracks of the public mental health system and landing in the criminal justice system at an alarming rate, straining local resources, consuming law enforcement time, crowding detention centers and prisons, and clogging court processes.[2] The lack of local crisis intervention programs often results in a "criminalization" of mental illness (i.e., charging a person with a minor crime so they can be detained in jail even though the underlying problem is mental illness) or "patrol car therapy" (i.e., transporting the person in hand cuffs to the Montana State Hospital (MSH). But, admission to the MSH requires the initiation of involuntary commitment proceedings and that makes the county ultimately responsible for all precommitment costs for detention, evaluation, and treatment if the individual, private insurance, or a public assistance program, such as Medicaid, does not cover the costs.[3]

Research highlights

Initial response - need for training and treatment alternatives

- When a person presents an imminent danger of bodily harm to themself or others because of a mental disorder, state law recognizes that an emergency situation exists and authorizes the person to be held in emergency detention, such as a hospital bed in a psychiatric unit, for evaluation and treatment.[4]

- Recognizing that a mental disorder may be involved can be a challenge for law enforcement. However, Crisis Intervention Team (CIT) training for local law enforcement and establishing working relationships with on-call mental health professionals (i.e., crisis teams) is a nationally recognized, proven strategy that helps law enforcement de-escalate potentially dangerous situations and divert people to treatment rather than holding them in jail on a minor charge, such as disorderly conduct.[5] Law enforcement officers from around Montana have participated in CIT training and several communities have established crisis response teams, but there is no statewide approach or state funding for these efforts.[6]

- Local law enforcement officers told the LJIC, that their biggest frustration is the lack of treatment alternatives and local crisis beds to which a mentally ill person picked up by law enforcement can be taken.[7]

Need for jail screening and diversion programs

- The increasing number of mentally ill inmates presents a significant treatment challenge for local detention and state corrections officials who told the LJIC that they are the largest mental health treatment providers in the counties and state.[8] According to the U.S. Bureau of Justice Statistics, about half of all prison and jail inmates have mental health problems*, and about three-fourths the inmates with mental health problems also have a substance abuse disorder.[9] An American Psychiatric Association study concluded that about 20% of all prison and jail inmates need psychiatric care, and about 5% are actively psychotic.[10]

- Montana state law requires detention centers to screen inmates for mental illness and develop jail diversion programs so mentally ill inmates

*A "mental health problem" was defined as having a recent (i.e., within the last 12 months) clinical diagnosis or treatment for symptoms of a disorder specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, commonly called the DSM-IV.

may be transferred to appropriate treatment alternatives, but the requirement is not state-funded.[11]

Local collaborations offer solutions

- Yellowstone County has developed a jail screening and diversion program, including crisis intervention services, through collaboration with private mental health service providers. County commissioners, sheriffs, detention officers, and private providers told the LJIC that this type of collaboration could serve as a model for other communities if state resources were made available to help. Yellowstone County's services include:
  - the Hub, which is a walk-in center for the homeless and mentally ill with services provided by the VA, Community Mental Health, and the Indian Health Service;
  - the Community Crisis Center, a collaborative between St. Vincent's Health Care, Billings Clinic, the City/County Health Department, and Community Mental Health, provides out-patient screening, stabilization, and referral services for people in crisis because of a mental health and addiction problem; and
  - the Billings Clinic psychiatric center, consisting of 44 beds. Yellowstone County contracts with the Billings Clinic for a mental health counselor to work in the Yellowstone County Detention Center about 5 hours a day. The Clinic also offers secure beds for emergency detention.
- These collaborative efforts, especially the Community Crisis Center, have been credited with reducing jail, emergency room, and MSH admissions.[12]

Precommitment costs

- Montana's state law provides that emergency detention beyond one business day requires that the county attorney file an involuntary commitment petition. Once a petition is filed, the county is the payer of last resort (which many stakeholders told the LJIC means the payer of *only* resort because most of the respondents are not insured and do not qualify for Medicaid) for all detention, evaluation, and treatment costs until the final disposition of the case.[13] Some stakeholders are concerned that county attorneys decide not to file commitment petitions solely because of the costs; thus, the mental illness goes untreated, problems escalate, and the person may ultimately end up in jail or prison.[14]

- Prior to a commitment petition being filed and whenever a county attorney decides to not file a commitment petition, private providers are on the hook for the unrecoverable costs. These costs can be significant. St. Patrick Hospital in Missoula testified that the hospital's charity care for mental health treatment alone amounted to more than $2.8 million in FY07.[15]

Bill summary

The following summary outlines the main components of HB 130 (LC0307) to provide a grant program for local crisis intervention and jail diversion programs:

- To the extent funding is appropriated by the legislature, DPHHS would offer grants to eligible counties for up to 50% of their prior fiscal year expenditures made for eligible jail diversion and crisis intervention programs. The DPHHS formula for determining the amount of the grants would reward counties who reduced their admissions to the MSH for emergency detention.

- DPHHS would determine, by rule, what expenses would be eligible for reimbursement through the grant. The bill specifies that premiums for a precommitment insurance pool must be considered an eligible expense.

- To be eligible for a grant, a county must:
  - apply for it;
  - have a strategic plan approved by DPHHS;
  - participate in a county insurance pool for precommitment costs, if such a pool has been established for counties;
  - participate in a state-contracted jail suicide prevention program, if one has been established and is available to the county (see the next section summarizing LJIC's recommendation for HB 60 (LC0329)); and
  - collect and report performance data to the DPHHS.

- The bill appropriates $615,937 from the state general fund in each year of the biennium (based on preliminary estimates by DPHHS, which are subject to change).

- The target date for full implementation is July 1, 2010, and a progress report would be made to the LJIC.

Policy goals

HB 130 (LC0307) was drafted to accomplish the following policy goals, which were articulated during various committee meetings and in meetings and interviews between staff and stakeholders, including state administrators, county commissioners, county attorneys, public defenders, consumer advocates, and consumer family members:

- to help local governments implement current statutes concerning crisis intervention and jail diversion for the mentally ill;

- to give counties an incentive to collaborate with the state, others communities, and private mental health service providers, to develop local and regional solutions; and

- to reduce reliance on MSH as the default crisis intervention service.

Recommendations of the Children, Families, Health and Human Services Interim Committee (CFHHS)

- In 2007, the Montana legislature appropriated $200,000 for a contracted, state-wide study of mental health services. The final report and study recommendations[16] were presented to the CFHHS after the LJIC had concluded its business for the interim.

- The contracted mental health study identified local crisis services as a priority need in Montana and the CFHHS voted unanimously to recommend the following amendments to LC0307, now HB 130:

  - include specific language to ensure that county expenditures for CIT training for law enforcement would be considered an eligible expense;

  - make the grant program available to "collaboratives," such as the Billings Community Crisis Center, rather than to a county alone; and

  - use the grant to match county precommitment costs, but only if the county is an active financial participant in the collaborative.[17]

ENDNOTES FOR SECTION ON HB 130 (LC0307)

1. See sequential intercept chart available online at http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf. GAINS stands for Gather, Assess, Interpret, Network, and Stimulate change.

2. See Council of State Governments, *Criminal Justice / Mental Health Consensus Project*. New York: Council of State Governments, June 2002, available online at http://consensusproject.org/the_report/. See also Zachary Franz, "Care for mentally ill can overwhelm jail, emergency services", *Great Falls Tribune,* September 2, 2008; Jennifer McKee, "Mentally ill crowd state jails: Also clog courts, prisons", *The Montana Standard*, October 2, 2007; Perry Backus, "Sheriff: Mentally ill strain Ravalli resources", *Missoulian*, January 1, 2007; and Ed Kemmick, "The default psychiatric center", *Billings Gazette*, March 2, 2008.

3. Law and Justice Interim Committee (LJIC), *Minutes*, Montana Legislative Services Division, October 1, 2007.

4. Section 53-21-129, Montana Code Annotated (MCA).

5. Jennifer Teller, Mark Munetz, Karen Gil, Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls", *Psychiatric Services,* Februrary 2006, Vol. 57, No. 2. See also, Melissa Reuland, *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness*, TAPA Center for Jail Diversion, U.S. Department of Health and Human Services, January 2004, also available online at http://gainscenter.samhsa.gov/pdfs/jail_diversion/PERF.pdf

6. Becky Shay, "Emergency responders to get training in helping mentally ill", *Billings Gazette*, March 22, 2007. See also, LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007.

7. LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007.

8. Ibid.

9. Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates,* U.S. Department of Justice, Special Report NCJ 213600, September 2006.

10. DPHHS, *Montana Strategic Suicide Prevention Plan*, pp. 33-34. Updated as of Summer 2008.

11. Section 53-21-138, MCA.

12. LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008. Testimony from Bill Kennedy, Yellowstone County Commissioner.

13. Section 53-21-132, MCA.

14. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007. Panel on HJR 50 - precommitment process and costs.

15. Ibid.

16. DMA Health Strategies, *Report to the State of Montana: Legislative Mental Health Study*, November 18, 2008. Available online through www.leg.mt.gov, follow links to the Children, Families, Health, and Human Services Interim Committee website for the 2007-2008 interim.

17. Children, Families, Health and Human Services Interim Committee, *Minutes*, Montana Legislative Services Division, October 14, 2008.

HB 60 (LC0329) - JAIL SUICIDE PREVENTION PILOT PROJECT

Problem

In 2005, Ravalli County residents were demanding answers from the county sheriff for a series of three suicides in two months by inmates at the detention center. Outraged family members alleged the jail's staff failed to implement proper suicide prevention protocols even though the men were known to be suicidal.[1]

In May 2007, Tia Henriksen, 23, and mother of a toddler, hung herself from an air vent inside her jail cell at the Cascade County Detention Center. The vent had allegedly been used at least once previously for the same suicidal purpose. The family recently filed a lawsuit against the county for negligence and for not having appropriate suicide prevention procedures in place. [2]

On November 5, 2007, after being booked into the Custer County Detention Center for a probation violation stemming from a felony Driving Under the Influence conviction and threatening suicide, Linda Wilson was allegedly left unobserved in an unsecured cell. She hung herself with a telephone cord. In April 2008, her husband and daughter filed a civil lawsuit for wrongful death.[3]

Between 2003 and 2007, 18 Montana citizens committed suicide while incarcerated, 14 were in county jails.[4] This rate is 5 times higher than the national average, based on statistics for the number of suicides per 100,000 inmates.[5] The death of someone while in county custody is not only a personal and family tragedy, it is a traumatic experience for detention staff and can lead to costly lawsuits against the county for a wrongful death. The national suicide rate in jails with less than 100 beds is ten times higher than in larger jails[6] because smaller jails often lack access to mental health professionals, suicide-restraint cells, and the level of staffing needed for constant observation.[7]

Research highlights

- There are six minimum requirements that a state prison or local jail must meet as a matter of constitutional law under the Eighth Amendment to the U.S. Constitution, which prohibits cruel and unusual punishments:

  (1) a systematic program for screening inmates to identify those who require mental health treatment for a serious mental disorder;
  (2) treatment must entail more than segregation and close supervision of inmates suffering from serious mental disorders;

  (3) treatment must involve participation by trained mental health professionals, employed in sufficient numbers to identify and treat, on an individual basis, treatable inmates suffering from serious mental disorders;

  (4) maintenance of accurate, complete, and confidential mental health records;

  (5) appropriate supervision and evaluation concerning the use of behavior-altering drugs; and

  (6) a basic program of identification, treatment, and supervision of prisoners with suicidal tendencies.[8]

- As previously noted, according to the U.S. Bureau of Justice Statistics, about half of all prison and jail inmates have mental health problems,[*] and about three-fourths of these inmates have a co-occurring substance abuse disorder.[9] An American Psychiatric Association study concluded

[*] A "mental health problem" was defined as having a recent (i.e., within the last 12 months) clinical diagnosis of or recent treatment for symptoms of a disorder specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, commonly called the DSM-IV.

that about 20% of all prison and jail inmates need psychiatric care, and about 5% are actively psychotic.[10]

- Mental health professionals agree that suicide risk does not directly coincide with mental illness and that, in fact, those most at risk of suicide are usually not mentally ill. Suicide risk is highest immediately after a person is booked into jail, immediately following a hearing, or immediately following sentencing.[11]

- In response to a series of publicized jail suicides in Kentucky, the 2004 Kentucky Legislature enacted and funded a jail suicide screening and prevention program that reduced Kentucky's jail suicide rate by 80%.

- The Kentucky program is now recognized as a national model. The model program provides:
  - standardized screening instruments;
  - a telephonic triage system with mental health professionals;
  - standardized suicide risk management protocols; and
  - follow-up measures.[12]

Bill summary

The LJIC's bill recommendation, LC0329 (now HB 60), creates a two-year pilot program that would establish a mental health triage system based on the Kentucky model for a sample of small, medium, and large population counties. The main components of the bill are outlined below.

- Requires DPHHS to contract with a mental health provider, such as a community mental health center, for the creation of a jail suicide prevention program consisting of:

  (a) a screening form with questions to be answered by the detention staff and possibly by the arresting officer;

(b) a 24-hour, seven days per week, electronic communications link between the detention staff and a mental health professional, perhaps at a community mental health center;

(c) a computer-assisted, guided interview with the detention staff and perhaps the prisoner, after which the mental health professional would advise the detention staff that the detainee's potential for suicide is "critical", "high", "moderate", or "low";

(d) the use of jail management protocols to care for the detainee or prisoner according to the individual's potential for suicide; and

(e) follow -up counseling in the jail of any individual whose risk for suicide is "critical" or "high", in order to reduce that risk to a lower level.

- Requires that every inmate in a participating county jail be screened for suicide potential using the triage system to be created by contract.
- Requires that the DPHHS adopt administrative rules to create the pilot program.
- Requires data collection and a report to the LJIC on the operations and findings of the pilot program.
- Appropriates from the state general fund $264,000 for FY2010 and $189,000 for FY2011, based on preliminary estimates that are subject to change during the session.

Although the LJIC initially voted not to add to the bill a grant program to help counties cover costs, such as for video monitors and additional detention center staff, the bill sponsor, Rep. Ebinger, supported the grant program. Because the LJIC gave bill sponsors implicit authority to act on the LJIC's behalf in finishing the drafting and introducing the committee bills[13] and acting with the support of

other committee members, including the chairman, Rep. Ebinger instructed that the bill draft be revised to include the grant program.

Policy goals

HB 60 (LC0329) was drafted to accomplish the following policy goals for the counties that would be involved in the pilot project:

- to help counties meet their constitutional obligation to provide mental health care, including suicide prevention, for inmates of county detention centers;

- to take advantage of Montana's existing telecommunications capabilities and connect mental health service providers in larger population centers with detention centers in rural areas where there are provider shortages; and

- to standardize suicide screening instruments and prevention protocols based on best practices.

Recommendations of the Children, Families, Health and Human Services Interim Committee (CFHHS)

- As previously noted, during the 2007 session, the Montana legislature appropriated $200,000 for a contracted, state-wide study mental health services. The final report and study recommendations[14] were presented to the CFHHS after the LJIC had concluded its business for the interim.

- The contracted mental health study identified jail screening for mental disorders as a need in Montana and the CFHHS voted unanimously to recommend that LC0329 (now HB 60) be amended to include screening and followup protocols for mental disorders, not only for suicide risk.[15]

ENDNOTES FOR SECTION ON HB 60 (LC0329)

1. Timothy Mitchell, "Inmate suicide epidemic: Sheriff Chris Hoffman addresses concerns over three inmate deaths in two months", *Ravalli Republic*, May 24, 2005.

2. Zachary Franz, "County sued over prison suicide", Great Falls Tribune, December 18, 2008.

3. David Niss, *No. 1 - Custer County Jail Suicide Case Study and Analysis*, a Montana Legislative Services Division legal memorandum to the Law and Justice Interim Committee (LJIC), dated June 13, 2008, also available online through www.leg.mt.gov, follow the links to the LJIC website for the 2007-2008 interim, June 26, 2008, meeting materials.

4. DPHHS, *Montana Strategic Suicide Prevention Plan*, pp. 33-34. Updated as of Summer 2008.

5. This is based on a Montana jail inmate population of 1,521, which was reported by DMA Health Strategies in its *Report to the State of Montana: Legislative Mental Health Study*, November 18, 2008, pg. 107. This report is available online through www.leg.mt.gov, follow the links to the Children, Families, Health, and Human Services Interim Committee for the 2007-2008 interim.

6. Ibid.

7. Suicide Prevention Center, "What Corrections Professionals Can Do to Prevent Suicide", October 2007.

8. For a thorough discussion of the relevant constitutional law, case studies, and policy implications discussed by the LJIC, see David Niss, *Constitutional and Federal Law Requirements for Mental Health Care for Convicted Offenders, Jailed Persons, and Detainees in Montana*, a legal memorandum to the LJIC dated September 14, 2007, also available online through www.leg.mt.gov, follow the links to the LJIC website for the 2007-2008 interim. See also, Cohen, *The Mentally Disordered Inmate and the Law*, Civic Research institute, 1998. See also, LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007. See also, LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008, including Exhibit 19, David Niss, *No. 4 - Kentucky Jail Mental Health Crisis Network, Issues and Options*, a legal memorandum to the LJIC, dated June 13, 2008, also available online through www.leg.mt.gov, follow the links to the LJIC website for the 2007-2008 interim.

9. Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates,* U.S. Department of Justice, Special Report NCJ 213600, September 2006.

10. DPHHS, *Montana Strategic Suicide Prevention Plan*, pp. 33-34. Updated as of Summer 2008.

11. Subcommittee on Jail Standards and Suicide Prevention, LJIC, *Minutes*, Montana Legislative Services Division, July 17, 2008.

12. David Niss, *No. 4 - Kentucky Jail Mental Health Crisis Network, Issues and Options*, dated June 13, 2008, a legal memorandum to the LJIC dated June 13, 2008. See also LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008.

13. LJIC, *Minutes*, Montana Legislative Services Division, September 15, 2008.

14. DMA Health Strategies, *Report to the State of Montana: Legislative Mental Health Study*, November 18, 2008. Available online through www.leg.mt.gov.

15. Children, Families, Health and Human Services Interim Committee, *Minutes*, Montana Legislative Services Division, October 14, 2008.

HB 131 (LC0516) - STATE CONTRACTING FOR REGIONAL CRISIS AND EMERGENCY DETENTION BEDS

Problem

When a person presents an imminent danger of bodily harm to themself or others because of a mental disorder, state law recognizes that an emergency situation exists and authorizes law enforcement to step in.[1] State law also provides that a mental health professional may keep the person for evaluation and treatment on an involuntary basis for no longer than 24 hours or until the next business day.[2] For that period of time, if the person is unable to pay or uninsured and is not eligible for public assistance, such as Medicaid, the hospital cannot recover the costs and the costs become part of the hospital's "charity care". Hospitals told the Law and Justice Interim Committee (LJIC) that their costs were increasing and were an unfair burden on private providers.[3]

In many Montana communities, there are very few crisis intervention or emergency detention beds available, so law enforcement and mental health professionals often rely on transporting the person, sometimes hundreds of miles, in handcuffs, to the Montana State Hospital (MSH) in Warm Springs.[4] This not only increases admissions to the MSH, but also results in significant costs to counties for transportation.

Research highlights

- In FY2007, there were 427 admissions to the MSH for emergency and court-ordered evaluations and, of those, 266 resulted in involuntary commitments, which translates to 63% percent of MSH admissions being for emergency and court-ordered detention pending a commitment hearing, and 38% of these not resulting in a commitment.[5]

- The MSH's average daily population has been consistently above its licensed capacity of 189, which strains MSH resources.[6]

- County costs for transportation to the MSH are significant. Lewis and Clark County Sheriff Cheryl Liedle told the LJIC that her deputies transported 111 people to the MSH between January and October 2007. Sheriff Leidle estimated the annual cost for transportation alone to be between $30,000 and $40,000, equivalent to a full-time position.[7]

- Of the 36 counties that responded to a survey on precommitment costs, 18 said they relied solely on the MSH for emergency detention; others relied on the MSH as well as local hospitals with psychiatric units.[8] Only four community hospitals in Montana have psychiatric units; they are in Kalispell, Great Falls, Missoula, and Billings.

- Respondents to the survey said they would rather use local or regional beds if they were available and could be offered at an affordable daily rate that at least offset their transportation costs.[9]

- Hospital rates reported in the survey ranged from $900 to almost $1,500 per day. Rates at MSH average about $450 to $500 per day. The average length of stay for emergency detention (whether at the MSH or at a community hospital) was about 3 to 5 days,[10] but the LJIC was informed on several occasions the length of state can be twice or three times as long because the legal process gets bogged down.

- As previously noted, community hospitals told the LJIC that they are being asked to shoulder an inordinate share of the burden for initial crisis intervention services. St. Patrick Hospital in Missoula testified that their charity care for mental health treatment alone amounted to more than $2.8 million in FY07.[11]

- The need to provide secure treatment (i.e., keep a person involuntarily) presents licensure and liability issues for mental health service providers. The Western Montana Mental Health (WMMH), which provides mental

health services throughout the western mental health service area, is developing crisis beds in Butte and Bozeman, but whether they will be able to provide the level of care necessary for an emergency or court-ordered detention equivalent to what is now provided at the MSH or a local hospital's psychiatric unit remains to be worked out.[12]

- In Helena, the Center for Mental Health has established the Montana House, which offers a voluntary day treatment "safe house" for people in crisis, but it cannot offer inpatient treatment or emergency detention services.[13]

- Montana is challenged by a shortage of mental health professionals who can provide the psychiatric services needed for emergency detention and evaluation. Interested persons and primary stakeholders agreed that regional facilities would be the most economical way to share costs and provider services if such facilities could be licensed accordingly and if state funding were available to help.[14]

- Notably, Yellowstone County developed partnerships with local providers (i.e., the Hub, the Billings Clinic, and the Community Crisis Center). As a result, fewer commitment petitions were filed and the county significantly reduced its precommitment costs, which were more than $300,000 in FY2004, but which were less than $65,000 by FY2007.[15]

Bill summary

The main components of HB 131 (LC0516), the LJIC's recommendation that the state contract for regional emergency detention beds, are:

- Provides that to the extent funding is appropriated by the legislature, the DPHHS would contract for up to three beds in each of the four mental health service areas for:

  - inpatient crisis intervention treatment to cover the time period from initial intake at a hospital to the filing of an involuntary

commitment petition or, if a commitment petition is not filed, to cover the first 24 hours or until the next business day when the person must be released; and

- emergency or court-ordered detention after the filing of a commitment petition has been filed and pending a court determination on the petition.

- Provides that the costs for initial inpatient crisis intervention services, the state will be ultimately responsible to pay any unrecoverable costs;* though after a petition is filed, the costs will still become precommitment costs under current law and the county will remain ultimately responsible for the costs.[16]

- Requires the collection and reporting of data to DPHHS and that the DPHHS adopt rules to administer the program.

- Appropriates $410,625 from state general fund money in each year of the biennium, based on preliminary estimates that could change during the session.

- Allows phased implementation, with contracting in at least one region by July 1, 2010, and full implementation in all four regions by July 1, 2011.

Policy goals

HB 131 (LC0516) was drafted to accomplish the following policy goals, which were articulated during various committee meetings and in meetings and interviews between staff and stakeholders, including state administrators, county commissioners, county

* Because current law prohibits a person from being held involuntarily for longer than 24 hours or the next business day without the filing of an involuntary commitment petition, the costs being covered by the state until LC0516 would be for inpatient treatment during the initial 24 hours or over the weekend or holiday (until the next business day) when the person would have to be released if a petition has not been filed.

attorneys, public defenders, consumer advocates, and consumer family members:

- to provide for emergency detention in mental health facilities closer to home than the MSH;
- to reduce MSH admissions for emergency detention; and
- to provide state funding to assist counties with precommitment costs.

ENDNOTES FOR SECTION ON HB 131 (LC0516)

1. "Emergency situation" is defined in section 53-21-102, Montana Code Annotated (MCA), as "a situation in which any person is in imminent danger of death or bodily harm from the activity of a person who appears to be suffering from a mental disorder and appears to require commitment."

2. Section 53-21-129, MCA.

3. Law and Justice Interim Committee (LJIC) *Minutes*, Montana Legislative Services Division, November 9, 2007. HJR 50 panel discussion.

4. LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007. Intercept 1 - panel discussion with Lewis and Clark County Sheriff Cheryl Leidle, Sweetgrass County Sheriff Dan Tronrud, and Addictive and Mental Disorders Division Administrator Joyce DeCunzo. Audio time 01:28:39.

5. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs,* April 10, 2008. See Tables 4 and 5 for data provided by the MSH. See also LJIC, *Minutes,* April 10, 2008

6. Lois Steinbeck, *Montana State Hospital Update June 2008*, Montana Legislative Fiscal Division, prepared for the Legislative Finance Committee, June 4, 2008.

7. LJIC, *Minutes*, October 1, 2007. Intercept 1 - panel discussion with Lewis and Clark County Sheriff Cheryl Leidle, Sweetgrass County Sheriff Dan Tronrud, and Addictive and Mental Disorders Division Administrator Joyce DeCunzo. Audio time 01:28:39.

8. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs,* April 10, 2008. See also LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008.

9. Ibid. Written comments provided as an attachment.

10. Ibid. See also LJIC, *Minutes,* Montana Legislative Services Division, April 10, 2008.

11. Ibid.

12. Ibid. Testimony of Paul Meyer, Executive Director, Western Montana Mental Health (WMMH). Audio time: 04:45:05. Also, public comment by Patty Kent, Housing and Development Director WMMH. Audio time: 06:42:54.

13. Ibid. Public comment by Patti Jacques of Helena. Audio time: 06:48:08.

14. LJIC, *Minutes,* Montana Legislative Services Division, April 10, 2008, and June 26, 2008.

15. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs,* April 10, 2008. See Table 9. See also, LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008.

16. Section 53-21-132, MCA.

HB 132 (LC0517) - DIVERSION FROM INVOLUNTARY COMMITMENT TO SHORT-TERM TREATMENT

Problem

County commissioners, mental health professionals, attorneys, judges, and mental health advocates share frustrations with the current involuntary commitment process and costs. These frustrations are summarized below.

- Mental health professionals are frustrated by the clash between medical standards concerning treatment needs and the legal standard for involuntary commitment.

- Attorneys are frustrated by the adversarial legal process that requires an all-or-nothing commitment determination by the court (i.e., either a commitment to the Montana State Hospital (MSH) for up to 90 days or no treatment at all).

- For judges, commitment hearings are time consuming and represent a significant caseload and workload.

- County commissioners are frustrated by high and unpredictable costs that begin when a commitment petition is filed and continue to be incurred while the legal process plays out.

- Mental health advocates are frustrated by the lack of community-based mental health services, which results in calls to law enforcement and over-reliance on involuntary commitment to the MSH.[1]

Research highlights

- For a mental health professional to hold a patient in secure treatment for more than one business day, state law requires that the county attorney file an involuntary commitment petition.[2]

- When an involuntary commitment petition is filed, the county becomes ultimately responsible for all precommitment, evaluation, and treatment costs. County precommitment costs were found to be significant, extremely unpredictable, and especially problematic for smaller counties. In Hill County, precommitment costs were reported to be more than $40,000 in FY 2005, but were only $750 the next year.[3]

- Between FY 2004 and FY 2007, some of the highest precommitment costs reported in the HJR 50 survey were:
  - $402,537 in Missoula County for FY 2005;
  - $317,282 in Yellowstone County for FY 2004;
  - $178,148 in Ravalli County in FY 2007;
  - $108,700 in Cascade County in FY 2005;
  - $67,1214 in Lewis and Clark County for FY 2005; and
  - $62,265 in Gallatin County for FY 2004.[4]

- In FY 2007, there were 427 admissions to the MSH for emergency or court-ordered evaluations pending a commitment hearing. Of those, 266 resulted in involuntary commitments. As noted in the summary for HB 131 (LC0516), the committee bill on emergency detention, 63% of MSH admissions were for emergency and court-ordered detention pending a commitment hearing, and 38% of the cases did not result in a commitment.[5]

- The MSH's average daily population has consistently been above its licensed capacity of 189, which strains MSH resources.[6]

- According to the MSH Administrator, Ed Amberg, many people committed to the MSH can be and are released prior to the 90-day

commitment period and voluntary treatment is more successful than involuntary treatment. [7]

- Oregon law allows a person to be diverted from involuntary commitment to an alternative 14-day intensive inpatient treatment program, if the respondent's attorney agrees and a short-term treatment bed is available.[8]

- County commissioners, county attorneys, public defenders, state agency officials, mental health professionals, and mental health advocates, and interested persons supported a short-term diversion alternative to involuntary commitment at the MSH similar to what is provided for in Oregon.[9]

Bill summary

The main provisions in HB 132 (LC0517) to allow a person to be diversted from involuntary commitment to short-term inpatient treatment are:

- Establishes a 14-day inpatient treatment program as an alternative to involuntary commitment.

- Requires the court to inform the respondent of the diversion alternative and provides that the professional person appointed by the court to conduct an evaluation must make a determination and recommendation about whether the respondent should be diverted to short-term inpatient treatment.

- Provides that if a diversion determination is made, the court shall suspend the commitment hearing unless the county attorney or the respondent's attorney objects within 24 hours.

- Provides that the payment responsibility for the treatment costs will be billed as is currently done for precommitment costs (to the individual,

private insurance, or a public assistance program) except that the state, not the county, will ultimately be the payer of last resort.

- Allows a treatment provider to release a respondent earlier than 14 days; but specifies that a commitment hearing must be held if:
  - the treatment provider wants to keep the respondent longer than 14 days;
  - the respondent refuses treatment;
  - the respondent's attorney requests the release prior to the end of the 14-day treatment period; or
  - the county attorney objects to an early release.

- Specifies that short-term treatment patients must receive a full medical and mental health examination within 24 hours of admission; provides for the patient's treatment rights, for treatment and discharge planning, and for safety requirements.

- Requires DPHHS to contract for up to three short-term inpatient treatment beds within each of the four mental health service areas and requires data collection and reporting. Gives DPHHS rulemaking authority for the program.

- Appropriates $1.7 million from the state general fund in each year of the biennium, based on preliminary estimates provided by DPHHS, which are subject to change.

Policy goals

HB 132 (LC0517) was drafted to accomplish the following policy goals, which were articulated during various committee meetings and in meetings and interviews between staff and stakeholders, including state administrators, county commissioners, county attorneys, public defenders, consumer advocates, and consumer family members :

- to offer an alternative to an adversarial, all-or-nothing commitment process;
- to shorten the precommitment process and reduce county costs;
- to allow a respondent to avoid the stigma of an involuntary commitment to the MSH;
- to reduce the workload for county attorneys, public defenders, and judges; and
- to reduce the number of admissions to the MSH.

ENDNOTES FOR SECTION ON HB 132 (LC0517)

1. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007, testimony of HJR 50 panelists, Bill Kennedy, Yellowstone County Commissioner, Merle Raph, Toole County Attorney and President of the Montana County Attorney Association (MCAA), Brett D. Lenneweber, Park County Attorney, the Honorable Kurt Krueger, District Judge in the 2nd Judicial District (Silver Bow County), Ed Amberg, Administrator, MSH, Joan Daly, Billings Clinic, Merry Hutton, St. Patrick Hospital, Linda Bradford, St. Patrick Hospital, and John Honsky, RN, Missoula and researcher of commitment proceedings in the 4th Judicial District. See also, LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008, testimony of HJR 50 panel and associated public comment by Bill Kennedy, Yellowstone County Commissioner; Merle Raph, Toole County Attorney and President of the MCAA,; Leo Galleghar, Lewis and Clark County Attorney; Kevin Gillan, Yellowstone Deputy County Attorney; Erin Olson, Kelly Harrison, and Dr. Laura Wendland, Office of State Public Defender; Ed Amberg, MSH Administrator; Anita Roessman, Disability Rights Montana; Mitzi Anderson, member of the National Alliance for the Mentally Ill - Montana Chapter. See also, LJIC *Minutes*, Montana Legislative Services Division, June 26, 2008, HJR 50 discussion.

2. Section 53-21-132, MCA.

3. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs,* Montana Legislative Services Division, April 10, 2008. See Table 9.

4. Ibid.

5. Ibid. Tables 4 and 5. Data provided by the MSH.

6. Lois Steinbeck, *Montana State Hospital Update June 2008*, Montana Legislative Fiscal Division, prepared for the Legislative Finance Committee, June 4, 2008.

7. LJIC, *Minutes,* Montana Legislative Services Division April 10, 2008. Testimony by Ed Amberg, Administrator, MSH.

8. Section 426.237, Oregon Revised Statutes. See also information provided by Anita Roessman, Disability Rights Montana summarized in LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008. Exhibit #15. See also, Sheri Heffelfinger, *Presentation Outline: Precommitment Process and Costs (HJR 50) - Progress Report, Summary of Montana Statutes, Comparison with Oregon Diversion Program, Staff Analysis So Far*, LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008, Audio time: 03:38:10.

9. LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008.

PART II - SJR 6 AND HJR 26
STUDIES OF THE JUVENILE JUSTICE SYSTEM AND MENTAL HEALTH TREATMENT FOR JUSTICE-INVOLVED YOUTH

Study priorities

Focus on mental health

- The Law and Justice Interim Committee (LJIC) adopted a study plan that combined the study tasks under SJR 6 with the HJR 26 study tasks that focused on mental health treatment in the juvenile justice system.

Residential treatment

- After considering of a range of issues for justice-involved youth, including several panel discussions about community mental health services, the court system, detention and incarceration, and re-entry, the LJIC identified residential psychiatric treatment needs for justice-involved youth as the most pressing need. In designating this as a top priority, committee members acknowledged that preventing mentally ill youth from ever entering the justice system was the preferred solution. Nonetheless, members also acknowledged the fact that mentally ill youth do enter the justice system and that some of these youth will require residential psychiatric treatment. Because the LJIC's jurisdiction does not include family services and early intervention programs, but relates to needs once the youth is in the juvenile justice system, priority was given to residential treatment needs for justice-involved youth.[1]

Problem

Unmet inpatient residential treatment needs

When a youth is suffering from a mental disorder that is not recognized or treated, the youth may engage in dangerous and disruptive behaviors, such as using alcohol or drugs, attempting suicide, cutting or other self-mutilation, or verbal or physical aggression against classmates, parents, or other authority figures. Such behaviors often result in the youth being "ticketed" for an offense and entering the juvenile justice system, where, unless the mental disorder is identified and treated, the youth's behavior pushes the youth deeper into the juvenile justice system and towards incarceration.[2]

The number of youth with a mental disorder who end up in the juvenile justice system are staggering. According to national several studies, between 65% to 70% of all justice-involved youth suffer from a diagnosable mental disorder; and in 25% of these cases, functional impairment is significant.[3] About 50% of the youth who suffer from a mental disorder also have a co-occurring substance abuse problem.[4]

Inappropriate use of juvenile detention

Testimony to the LJIC indicated that youth court judges may have no other alternative but to place a youth in detention for a mental health evaluation. Although current law allows a judge to place a youth in an assessment center for a multi-disciplinary assessment of education, chemical dependency, mental health, and other service needs,[5] the state of Montana has not funded these and there are no dedicated state emergency detention and treatment beds for youth.

Disproportionate minority contact

Another problem is that American Indian youth are over-represented in the youth justice system, particularly with regard to incarceration in either detention or a correctional facility. American Indians make up about 7% of the total population in Montana. Yet, in 2007, Montana's youth courts handled 6,692 different youth,

of which 846 (12.6%) were American Indian. American Indian youth were ticketed for 15.6% of all juvenile offenses;[6] and 39% percent of Montana's incarcerated youth are American Indians.[7]

Research highlights

Inpatient residential treatment alternatives

- A youth court may order a mental health evaluation for a youth at any time during the youth court process.[8] If a youth is found to have a mental disorder, the youth may not be placed in a youth correctional facility. If a youth is found to have a mental disorder after being placed in a youth correctional facility, the Department of Corrections (DOC) must move the youth to a mental health facility, which includes a residential treatment facility if necessary.[9]

- Although state law allows a youth court judge to directly commit a youth found to have a mental disorder to a mental health facility,[10] Montana does not have a state-administered residential psychiatric treatment facility, state law prohibits a youth from being treated at the Montana State Hospital (MSH), except when the youth is being processed as an adult,[11] and private treatment providers often decline to accept youth with difficult behavior problems, especially justice-involved youth.

- Montana has three in-state private residential treatment facilities that serve Montana youth: Shodair in Helena, Yellowstone Boys and Girls Ranch (YBGR) in Billings, and Acadia in Butte. As private providers, they may decline to accept a youth either because they do not have a bed available or the youth is too disruptive and difficult.

    - Of the 106 youth in the YBGR residential treatment program, which emphasizes a behavioral treatment model, only 10 of the youth are from Montana.[12]

- About 85% of the youth in Acadia's 69-bed residential treatment center in Butte are Montana youth. As a medical model facility, Acadia's program is focused on stabilizing a youth and returning the youth to the community as soon as possible.[13]

- Shodair is also a medical model facility, has 68 residential treatment beds and 28 acute care beds, and employs five child/adolescent psychiatrists, which is the highest concentration of child/adolescent psychiatrists in the state. Shodair rarely treats out-of-state youth.[14]

- Between July 1, 2007, and April 4, 2008:

  - only five justice-involved youth with serious mental disorders were placed with in-state private providers for treatment and all were eventually sent out-of-state.[15]

  - a total of 25 justice-involved youth were placed in out-of-state residential treatment facilities because they could not be placed in state: 15 were placed by DOC and 10 were placed by juvenile probation. Three youth in DOC youth correctional facilities could not be placed at all and remain in the correctional facilities.[16]

- As of February 2008, a total of 161 youth in the public mental health system were placed out-of-state for residential psychiatric treatment. These youth were not involved in the justice system and may not exhibit the more difficult behavioral problems that justice-involved youth may have, but may have some of the same mental health treatment needs as the justice-involved youth.[17]

- The estimated state general fund cost of placing an average of 18 justice-involved youth in out-of-state residential treatment facilities is more than $2 million annually.[18]

- The estimated cost of operating a 20-bed in-state youth residential treatment facility with 35 full-time staff is about $1.9 million, not including construction or building renovation costs.[19]

Juvenile detention and disproportionate minority contact

- Current law sets the criteria that must be met before a youth may be placed in detention. However, it also allows a judge to place a youth in detention based on any "additional criteria" set by the youth court.[20] The Montana Board of Crime Control's (MBCC) Youth Justice Council recommended legislation to eliminate this "loophole", but did not officially request the legislation as an agency bill.[21]

- Work by the MBCC led to stakeholders in the Great Falls, Missoula, and Havre areas agreeing to participate in the Juvenile Detention Alternatives Initiative (JDAI) offered by the Annie E. Casey Foundation. Under JDAI, stakeholders (including judicial, law enforcement, tribal, detention, and school officials) collaborate in a three-year effort to collect data and implement changes to reduce inappropriate detention, develop detention alternatives, and reduce disproportionate minority contact and confinement.[22]

- Current law allows a youth to waive the right to attorney representation during a probable cause detention hearing without first consulting an attorney.[23] Judges, attorneys, and probation officers agreed that youth should be represented by an attorney at these hearings.[24]

Actions, recommendations, outcomes

Residential treatment facility not pursued

- The LJIC considered whether Montana should build an in-state youth residential treatment facility. However, the LJIC chose not to move forward with the idea for the following reasons:

(a) some members and advocates had lingering concerns about the unintended consequences of establishing a state or state-contracted facility (i.e., the "if you build it they will fill it" mantra reflecting concern that the facility would be used inappropriately and cost more than anticipated);

(b) there were questions about whether one facility could meet the treatment needs of youth with varied, diverse diagnoses and that were now in different facilities out-of-state;

(c) there were questions about whether the facility would be Medicaid eligible; and

(d) representatives of Shodair, YBGR, and Acadia assured the LJIC they were committed to collaborating with the state to assess individual cases and possibly serve more justice-involved youth in-state.[25]

- On September 27, 2008, DOC and DPHHS issued a request for information to gage private provider interest in establishing a 24-hour psychiatric residential treatment facility to treat youth with mental illness or behavioral health issues. The department announced on November 21, 2008, that after review of the information received, they would not be moving forward on the idea, but that the information would be filed for possible future consideration. A memorandum summarizing this decision and the rationale for it is provided at Appendix C.[26]

Bill draft to clarify current law needed further work, not pursued

- The LJIC considered a bill draft to:

(a) clarify the statutes prohibiting the placement of a youth with a mental disorder in a correctional facility;

(b) create a definition of "disabling condition" under the Youth Court Act that would cover developmental disabilities, brain injuries, and mental disorders rather than rely on the involuntary commitment statutes to define mental disorder, which current law provides and which does not include developmental disabilities or brain injuries; and

(c) require a youth court judge to order a full mental health evaluation for a youth prior to ordering placement of a youth in a correctional facility, if such an evaluation has not already been done.[27]

- The bill draft needed further work on the disabling condition definition and to resolve concerns about how mental health evaluations would be conducted, by whom, and whether to mandate them.

- The LJIC chose not to recommend the draft bill as a committee bill, but acknowledged that DOC requested a similar bill (LC0311), which could be drafted and forwarded as an agency bill to address some of the issues the committee draft tried to address.[28] However, DOC announced on December 17, 2008, that it would not move forward the requested bill.[29]

Juvenile detention, hearing recommendation

- The LJIC expressed interest in continuing to monitor the progress of JDAI activities in Montana.[30]

- The LJIC voted to recommend to the 61st Legislature, LC0198 (now SB 91), a bill requiring that a youth be represented by an attorney at a probable cause detention hearing, unless the youth waives that right after the youth has consulted with an attorney.[31]

ENDNOTES FOR PART II ON SJR 6 AND HJR 26 STUDIES

1. Juvenile Justice Working Group, Law and Justice Interim Committee (LJIC), *Minutes*, Montana Legislative Services Division, January 11, 2008.

2. LJIC, *Minutes*, Montana Legislative Services Division, November 30, 2007, panel discussions.

3. Kathleen R. Skowyra and Joseph Cocozza, *A Blue Print for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System*, Research and Program Brief, National Center for Mental Health and Juvenile Justice, June 2006.

4. National Mental Health Association, *Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices*, 2004.

5. Sections 41-5-1203(2)(a) and 41-5-1512(1)(p), MCA.

6. LJIC, *Minutes*, Montana Legislative Services Division, January 10, 2008. Testimony by Bob Peake, District and Youth Court Services Bureau Chief, Judicial Branch. Audio time: 03:31:52.

7. Ibid. Exhibit 11 from Steve Gibson, *OJJDP DMC Reduction Best Practices Database*.

8. Section 41-5-1503(1), Montana Code Annotated (MCA).

9. Section 41-5-1504, MCA..

10. Section 41-5-1512, MCA.

11. Section 53-21-506, MCA.

12. LJIC, *Minutes*, Montana Legislative Services Division, June 27, 2008. Testimony from Jani McCall, Vice President, Government Relations, Yellowstone Boys and Girls Ranch, Billings.

13. Ibid. Testimony from Jim McVeigh, Director of Business Development, Acadia of Montana.

14. Ibid. Testimony from Jack Casey, Administrator, Shodair Children's Hospital, Helena.

15. LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008, Exhibit 4. Handout from Steve Gibson, Youth Services Division Administrator, Department of Corrections (DOC).

16. Ibid.

17. Ibid. Exhibit 6. Handout from Mary Dalton, Health Resources Division Administrator, Department of Public Health and Human Services (DPHHS).

18. Ibid.

19. LJIC, *Minutes*, Montana Legislative Services Division, June 27, 2008, Exhibit 29. Testimony by Steve Gibson, Youth Services Administrator, DOC.

20. Section 41-5-341(2)(f), MCA.

21. Juvenile Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, January 11, 2008, Audio time: 00:03:34.

22. Ibid. Exhibits 1 and 2. Expert testimony, including testimony from Bart Lubow, Director of Programs for High Risk Youth, Annie E. Casey Foundation, and working group questions and discussion about juvenile detention. Audio time: 00:03:34.

23. Sections 41-5-332 and 41-5-333, MCA.

24. Juvenile Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 29, 2008, Audio time starting: 01:00:45

25. LJIC, *Minutes*, Montana Legislative Services Division, June 27, 2008. See discussion and Exhibit 28 provided by Jack Casey of Shodair.

26. Deb Matteucci, Summary of Decision re: Psychiatric Residential Treatment Facility for Youth, memorandum dated December 1, 2008.

27. Ibid. Exhibit 26 and testimony by Mary Dalton, Health Resources Division Administrator, DPHHS.

28. LJIC, *Minutes*, Montana Legislative Services Division, September 15, 2008. Audio time: 04:17:20.

29. Mike Ferriter, email copied to Sheri Heffelfinger, December 17, 2008.

30. Juvenile Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, January 11, 2008, and February 28, 2008. See recommendations adopted by the full LJIC, *Minutes*, Montana Legislative Services Division, February 29, 2008.

31. Juvenile Justice Working Group, LJIC, *Minutes*, Legislative Services Division, February 28, 2008. See recommendations adopted by the full LJIC, *Minutes*, February 29.

PART III - SJR 24
STUDY OF PRISON POPULATION GROWTH AND DIVERSION TO TREATMENT

Study priority

In conducting the SJR 24 study, the Law and Justice Interim Committee (LJIC) focused on drug offenders and whether Montana's law should be changed to divert nonviolent drug offenders to treatment as an alternative to incarceration.

Key activities

The LJIC's key study activities were as follows:

- Review of the Department of Corrections (DOC) prison population reports and growth projections.
- Examination of drug offender sentencing data and correctional treatment alternatives.
- Examination of California's Proposition 96, which reformed drug offender sentencing and treatment alternatives in California, including a presentation by Mr. Daniel Abrahamson[1] and Ms. Tamar Todd,[2] Drug Policy Institute.

Research highlights

Prison population growth

- Of about 13,000 offenders in Montana's state adult corrections system, more than 80% are supervised by DOC are in community placements.[3]

- As of the first quarter of FY2008, the male prison population had been reduced by 4% and the female prison population had been reduced by 25%, mostly due to more community placements, diversion to treatment programs, and the use of the sanctions and assessment centers.[4]

- DOC projected a 3.4% annual growth rate in the male prison population, which would result in the Montana State Prison exceeding its current capacity by 132 inmates by FY2011.[5]

- DOC projected a 6.9% annual growth rate in the female prison population, which would result in the Montana Woman's Prison exceeding its capacity by 9 inmates by FY2011.[6]

Drug offenses and sentencing data

- Drug possession is the most common offense for which male and female offenders under DOC supervision have been convicted. Felony driving under the influence is the 3rd most common offense among men and the 6th most common offense among women. The sale of drugs ranks 5th most common offense among both men and women.[7]

- About 26% of the all offenses committed are drug offenses, with 58% of these offenses involving only drug possession and/or use (not including drug manufacture, distribution, possession with intent to sell, or fraudulently obtaining drugs).[8]

- Montana's current law allows judges to impose alternative sentences for drug offenses so that felony drug offenders can be enrolled in DOC treatment programs rather than imprisoned.[9]

- Based on 5 years of sentencing data, 95% of those convicted of felony drug possession or use received suspended, deferred, or alternative sentencing, while 5% (119 individuals) were sentenced to prison. Of those sentenced to prison, all but 6 had a record of prior drug offenses or other criminal offenses.[10]

- Between July 1, 2002, to July 1, 2006, of the offenders convicted for drug possession and/or use and who were sentenced to the DOC for placement, about 26% were placed in a treatment program.[11]

- DOC's residential chemical dependency treatment programs are:

Name	Location	Capacity	Program	Duration
WATCh West	Warm Springs	108 beds	DUI (males)	180 days
WATCh East	Glendive	42 beds	DUI (females/males)	180 days
Connections West	Warm Springs	52 beds	Alcohol & Drug (males)	60 days
Connections East	Butte	42 beds	Alcohol & Drug (males)	60 days
Passages	Billings	40 beds	Alcohol & Drug (females)	60 days
Elkhorn Center	Boulder	40 beds	Meth (females)	270 days
Nexus Center	Lewistown	80 beds	Meth (males)	270 days

Source: Department of Corrections.

- For FY 2008, DOC's expenditures for treatment programs were just over $15 million, with almost $14 million spent on contracted programs.[12] DOC's total general fund appropriation for FY2008 was just over $157 million,[13] which means that about 9.5% of DOC's budget for FY 2008 was spent on treatment.

- The total average population in DOC chemical dependency programs is about 930 offenders, with 51% of them in state-run (rather than contract provider) facilities. As of a February 2008 report to the LJIC, the total waiting list for these programs was 699 offenders.[14]

Actions, recommendations, outcomes

- The LJIC did not develop recommendations for legislative action under SJR 26.

- A comprehensive report from DOC providing further data on drug offenders is available from the Montana Legislative Services Division.[15]

ENDNOTES FOR SUMMARY OF SJR 24 STUDY

1. Law and Justice Interim Committee (LJIC), *Minutes*, Montana Legislative Services Division, November 9, 2007.

2. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 29, 2007.

3. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007. See Exhibits 5 and 6 and testimony and report by Gary Hamel, Health Planning and Information Services Division Administrator, Department of Corrections (DOC).

4. Ibid.

5. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007. Report by DOC.

6. Ibid.

7. DOC, *Biennial Report,* State of Montana, 2007.

8. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 28, 2008, Exhibit 9. DOC report on drug offender data.

9. Section 45-9-202, MCA.

10. Sheri Heffelfinger, *SJR 24 Drug Offender Sentencing Data Analysis*, Montana Legislative Services Division, November 2007, for the Law and Justice Interim Committee. Raw data provided by DOC.

11. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 28, 2008, Exhibit 9. DOC report on drug offender data.

12. Ibid. Exhibit 9, DOC report, p.1.

13. Montana Legislative Fiscal Division, *Profile of Department of Corrections*, October 2008.

14. Ibid. Exhibit 9, DOC report, p.1.

15. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 28, 2008, Exhibit 9. DOC report on drug offender data.

PART IV - IN SUMMARY

Recommendations

The LJIC recommends to the 61st Legislature for the 2009 Session the following bills:

- HB 130 (LC0307) - a grant program for community-based crisis intervention and jail diversion;
- HB 60 (LC0329) - a pilot project for a statewide jail suicide prevention program;
- HB 131 (LC0516) - state contracting for regional emergency detention beds; and
- HB 132 (LC0517) - diversion from involuntary commitment at the MSH to short-term inpatient treatment.

Goals

The overall goals of these for bills are to support community-based mental health services that will:

- reduce the number of mentally ill individuals held in local detention centers and ultimately prison;
- reduce county precommitment costs;
- reduce county admissions to the MSH for emergency detention; and
- reduce the number of mentally ill individuals committed to the MSH.

Funding

The bills rely on appropriations from the state general fund in the following amounts, which are based on the very preliminary estimates provided by DPHHS, so are subject to change during the 2009 Session:

	FY2010	FY2011
▸ HB 130 (LC0307)	$615,937	$615,937
▸ HB 60 (LC0329)	$264,000	$189,000
▸ HB 131 (LC0516)	$410,625	$410,625
▸ HB 132 (LC0517)	$1.7 million	$1.7 million